2025/2026 Influenza Vaccine Consent

Cedar County Public Health*400 Cedar St. Tipton, IA*(563) 886-2226

Patient Information

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:	GENDER (circle one): Male Female Other

DATE OF BIRTH: ___ ___ / ___ ___ / ___ ___ ___ ___	AGE:	PHONE NUMBER:

STREET ADDRESS/PO BOX:	CITY:	STATE:	ZIP CODE:

Please Answer ALL Questions *As it Applies to the Vaccine Recipient*	Circle One	
1. Have you ever had a severe reaction to a previous dose of flu vaccine?	Yes	No
2. Do you have a severe allergy to any components of the vaccine? (eggs, gelatin, latex)	Yes	No
3. Are you ill today, either with or without a fever?	Yes	No
4. Have you ever had Guillain-Barre Syndrome? (a type of temporary severe muscle weakness)	Yes	No

Consent for Vaccination

- The Vaccine Information Statement for the current influenza vaccine has been made available. I understand the risks & benefits.
- I give consent, to Cedar County Public Health to vaccinate the person named above, for whom I am authorized to make this request, with the recommended vaccine for his/her age and to record the vaccination in the Iowa Immunization Registry Information System (IRIS).
- I understand that my information or the person named above for whom I am authorized to make this request, may be disclosed for research or public health purposes as applicable by law.
- I understand that if my child is younger than 9 years of age may need a second dose of influenza vaccine this season. I am responsible for ensuring that my child receives the second dose.
- I certify that the information I provided for payment is correct. I authorize release of all records required to act on this request. I authorize Medicare, Medicaid, United Healthcare, and/or Blue Cross Blue Shield to make payments directly to Cedar County Public Health. If payment is denied, I am responsible for the charges.

Patient/Guardian Signature: _____ **Date:** _____

Payment Method

If you have a primary and secondary insurance please provide both*

◯ **Uninsured**

Insurance Company Name: (we accept United Healthcare-except plans by John Deere, Hawk-I, Blue Cross Blue Shield, Medicare, & Medicaid—If Medicaid, circle one: **Wellpoint, Iowa Total Care, or Molina**)

Identification Number: **Group Number:**

Name of Policy Holder:	Birthdate of Policy Holder: ___ ___ / ___ ___ / ___ ___ ___ ___

◯ **$30 Private Pay Circle One**: Cash Check *We are not able to accept credit/debit cards*

This Section for Office Use Only

◯ I have screened this patient for contraindications Nurse's Signature:_____ Date:_____	◯ Left Arm ◯ Left Thigh ◯ Right Arm ◯ Right Thigh	Sticker	In IRIS